Sanmarkan a/l Ganapathy & Anor (as administrators of the estate of Saradhamani a/p Doraisamy Gopal, the deceased) v Dato' Dr V Thuraisingham & Ors

HIGH COURT (PULAU PINANG) — CIVIL SUIT NO 22–19 OF 2006
CHEW SOO HO JC
29 JULY 2011

Evidence — Expert testimony — Conflicting testimony — Weight to be accorded — Whether evidence of defendants' second expert witness self-serving — Whether court found opinions of expert witnesses helpful in determining standard of care expected of first and second defendants as consultant physicians — Whether court was final arbiter in determining whether defendants breached standard of care

Tort — Negligence — Professional negligence — Medical practitioners — Standard of care — Whether there was lack of care — Whether failure or omission of first and second defendants to investigate and diagnose deceased as suffering from colon cancer constituted negligence — Whether court found opinions of expert witnesses helpful in determining standard of care expected of first and second defendants as consultant physicians — Vicarious liability — Whether third defendant vicariously liable for acts or omissions of first and second defendants — Whether plaintiffs proved damages as claimed — Limitation — Whether limitation applied to bar suit against second defendant

Madam Saradamani Doraisamy Gopal ('the deceased'), who passed away on 8 February 2005, had been consulting the first and second defendants, consultant physicians at the hospital of the third defendant from as early as 7 January 1980. The deceased had consulted the first and second defendants on eight occasions in total commencing from 7 January 1980 till her last visit on 15 December 2000. On these consultations she had been diagnosed as suffering from either *gastroenteritis* or food poisoning. On her visit to the first defendant on 15 December 2000, the first defendant had ordered an endoscopy, ultrasound of the deceased's abdomen, a *barium enema* and blood tests. These tests showed that the deceased was suffering from cancer of the colon which had spread to her lymph nodes, liver, lungs and bone at the third stage. On 20 December 2000 a surgery was carried out to remove the malignant tumour from the deceased's colon. Thereafter, the deceased had undergone chemotherapy and radiation which continued until she passed away. The first and second plaintiffs, the husband and the son of the deceased, claimed that the deceased could have been diagnosed as suffering from colon cancer much earlier than 15 December 2000, given her medical history,

complaints that she raised coupled with her age and facilities available to the first and second defendants. The plaintiffs, in their capacity as administrators of the deceased's estate, thus commenced the present action in negligence against the first and second defendants. It was the plaintiffs' case that the first and second defendants' failure or omission to diagnose the deceased of colon cancer earlier than 15 December 2000 constituted a breach of their duty of care and negligence. The plaintiffs submitted that as a consequence of such negligence the deceased's cancer spread and she was subjected to immense and prolonged pain and suffering until she succumbed to cancer and died. The plaintiffs also held the third defendant as vicariously liable for the acts of the first and second defendants. By way of this action the plaintiffs claimed various damages in the tort of negligence against the defendants. The first and second defendants denied the allegation of negligence. In their defence they submitted that there were no symptoms in the deceased prior to her consultation on 15 December 2000 that would have led a medical doctor practising as a consultant physician to reasonably embark on an investigation for colon cancer. The defendants relied on the evidence of their expert witness to prove that the signs or symptoms presented by the deceased to them did not warrant an investigation for colon cancer. The defendants' expert witness, a colorectal surgeon, was of the view that the deceased's symptoms prior to 15 December 2000 were not that of colon cancer but an acute *gastroenteritis*. To rebut this contention the plaintiffs called upon their expert witness, an oncologist and radiotherapist, who testified that the deceased's symptoms of anaemia, diarrhea, abdominal pain and vomiting were the classical presentation of colon cancer. The first and second defendants also called a second expert ('the defendants' second expert witness'), a consultant physician and endocrinologist to testify on their behalf, but the plaintiffs objected to the opinion of this expert witness on the grounds that his evidence was self-serving. The second defendant further pleaded limitation under s 6 of the Limitation Act 1953 ('Act'). The third defendant contended that as the first and second defendants were not its servants or employees, it was not vicariously liable for the acts or omissions of the first and second defendants.

Held, allowing the plaintiffs' claim against the first and second defendants with costs and dismissing the plaintiffs' claim against the third defendant with costs:

(1) The defendants' second expert witness was a member of the Medical Protection Society, a society that provides insurance to defend doctors in litigation, of which the first and second defendants were also members. In the circumstances, although this expert witness could probably be unbiased and honest, his opinion was nevertheless tainted with the probability of non-independence. Further, this court was bound by the decision held by the Court of Appeal in *Foo Fio Na v Hospital Assunta & Anor* [1996] 6 MLJ 738 to hold that the evidence of the defendants' second expert witness was self-serving since this witness had an interest in

A the decision to favour the first and second defendants. As such, it would be unsafe for this court to rely on such evidence to ensure a fair trial and no weight could be accorded to this expert's opinion (see para 20).

(2) The plaintiffs' expert witness was an oncologist, but this court had to bear in mind that both the first and second defendants were not oncologists but consultant physicians and should be judged in their profession as such. The standard of care between an oncologist, specialised in cancer and cancer treatment, and consultant physicians, who specialized in internal medicine, was glaringly different. Therefore the court could not judge the first and second defendants by the standard of an oncologist, who is differently skilled, but by what the reasonable doctor in that skill would have done (see para 22).

(3) The defendants' expert witness emphasised that there was no cause to suspect colon cancer because there was no change of bowel habit in the deceased. However, this court found that during the deceased's visit to the first defendant on 15 December 2000, the signs and symptoms did not involve any change of her bowel habit either but the defendants had carried out an endoscopy and other tests which led to the diagnosis of colon cancer. Thus, the change in bowel habits which the defendants' expert witness had emphasised to be the conspicuous sign or symptom in the case of colon cancer was not the tacit test to identify the probability or improbability of having colon cancer, particularly in the deceased. In any event there was no evidence that the first and second defendants had queried or investigated any bowel habit change in the deceased (see para 23).

(4) The physicians owed a duty to the deceased to use diligence, care, knowledge, skill and caution in administering treatment. From the facts and evidence as a whole, this court found that the first and second defendants as experienced consultant physicians ought to have investigated the deceased's medical condition further prior to 2000. The fact that the deceased had at least on four episodes complained of similar symptoms, when considered cumulatively, ought to have raised the first and second defendants' suspicions to probe further. Given the five episodes of the deceased's similar recurring medical complaint, as between 15 December 1992 to 5 October 2000, any medical doctor who possessed the skill and experience of the first and second defendants would have probably ordered further necessary investigation to rule out any other probable illness, including cancer. Consequently, the first and second defendants' failure or omission to investigate further prior to 15 December 2000 constituted a breach of the standard of care and amounted to negligence on their part (see para 26).

(5) The present cause of action accrued on 15 December 2000 when the deceased was confirmed to be suffering from colon cancer. Calculating six

years from 15 December 2000, the limitation would be on or about 15 December 2006. Since the plaintiffs' suit was filed on 12 January 2006, it was well within time and s 6(1) of the Act, did not apply to the second defendant (see para 29).

(6) The evidence of the first and second defendants showed that they were independent contractors who merely had an agreement with the third defendant to, inter alia, use its facilities. The plaintiff had the burden of proving that the third defendant was vicariously liable for the acts or omissions of the first and second defendants but it failed to produce any evidence to prove so. As such, the plaintiffs had failed to prove their case against the third defendant (see paras 30–32).

(7) The plaintiffs had led no evidence to show that but for the alleged delay in diagnosis of the colon cancer in the deceased, her medical condition, prognosis and outcome would have been different. Nevertheless, taking into consideration the pain and suffering suffered by the deceased because of the late diagnosis, this court held that a sum of RM100,000 would be a fair award for the pain and suffering of the deceased. The plaintiffs were also awarded special damages in the sum of RM8,280, being the costs of nursing care incurred by the plaintiffs in caring for the deceased (see para 40).

[Bahasa Malaysia summary

Madam Saradamani Doraisamy Gopal ('si mati'), yang meninggal dunia pada 8 Februari 2005, telah mendapatkan rawatan daripada defendan pertama dan kedua, pakar-pakar perubatan di hospital defendan ketiga seawal 7 Januari 1980. Si mati mendapatkan rawatan sebanyak lapan kali keseluruhannya bermula dari 7 Januari 1980 sehingga lawatan akhirnya pada 15 Disember 2000. Dalam rawatannya, dia didiagnosis mengalami, sama ada *gastroenteritis* atau keracunan makanan. Semasa berjumpa dengan defendan pertama pada 15 Disember 2000, defendan pertama menyuruh membuat endoskopi, ultrasound pada bahagian abdomen si mati, ujian *barium enema* dan ujian darah. Ujian-ujian ini menunjukkan bahawa si mati mengalami kanser kolon yang telah merebak ke nodus limfatik, hati, paru-paru dan tulangnya di peringkat ketiga. Pada 20 Disember 2000, satu pembedahan telah dilakukan untuk mengeluarkan tumor tersebut daripada kolon si mati. Kemudian, si mati telah menerima rawatan kemoterapi dan radiasi yang berterusan sehingga dia meninggal dunia. Plaintif pertama dan kedua, suami dan anak si mati, menuntut bahawa si mati mungkin didiagnosis mengalami kanser kolon lebih awal daripada 15 Disember 2000, kerana sejarah perubatannya, aduan yang dibangkitkannya ditambah dengan umur dan kemudahan yang terdapat pada defendan pertama dan kedua. Plaintif-plaintif, dalam kapasiti mereka sebagai pentadbir harta si mati, oleh itu memulakan tindakan ini atas kecuaian terhadap defendan pertama dan kedua. Adalah kes plaintif-plaintif bahawa kegagalan atau peninggalan defendan pertama dan kedua untuk mendiagnosis

si mati dengan kanser kolon lebih awal daripada 15 Disember 2000 membentuk pelanggaran kewajipan berjaga-jaga mereka dan kecuaian. Plaintif-plaintif menghujah bahawa akibat daripada kecuaian tersebut kanser si mati merebak dan dia terpaksa melalui kesakitan dan kesengsaraan yang teramat dan lama sehingga dia mati akibat penyakit kanser tersebut. Plaintif-plaintif juga menyatakan bahawa defendan ketiga bertanggungjawab secara vikarius atas tindakan defendan pertama dan kedua. Melalui tindakan ini plaintif-plaintif menuntut berbagai ganti rugi dalam tort kecuaian terhadap defendan-defendan. Defendan pertama dan kedua menafikan dakwaan kecuaian tersebut. Di dalam pembelaan mereka, mereka menghujah bahawa tidak ada simptom pada si mati sebelum rawatannya pada 15 Disember 2000 yang menjurus doktor perubatan yang beramal sebagai pakar perubatan untuk secara munasabah memulakan siasatan bagi kanser kolon. Defendan-defendan menyandar pada keterangan saksi pakar untuk membuktikan bahawa tanda-tanda atau simptom yang ditunjukkan oleh si mati kepada mereka tidak mewajarkan siasatan bagi kanser kolon. Saksi pakar defendan-defendan, pakar bedah kolorektum, berpendapat bahawa simptom si mati sebelum 15 Disember 2000 tidak menunjukkan kanser kolon tetapi *gastroenteritis* yang teruk. Untuk mematahkan hujahan ini, plaintif-plaintif mengemukakan saksi pakar mereka, seorang pakar onkologi dan radioterapi, yang memberikan keterangan bahawa simptom si mati iaitu anemia, cirit birit, sakit abdomen dan muntah-muntah menunjukkan kewujudan kanser kolon. Defendan pertama dan kedua juga memanggil pakar kedua ('saksi pakar kedua defendan-defendan'), seorang pakar perunding dan pakar endokrinologi untuk memberi keterangan bagi pihak mereka, tetapi plaintif-plaintif membantah pendapat saksi pakar ini atas alasan bahawa keterangannya adalah untuk kepentingan diri sendiri. Defendan kedua selanjutnya memplid had masa di bawah s 6 Akta Had Masa 1953 ('Akta'). Defendan ketiga menghujah bahawa oleh sebab defendan pertama dan kedua bukan kakitangan atau pekerjanya, ia tidak bertanggungjawab secara vikarius bagi tindakan-tindakan dan peninggalan defendan pertama dan kedua.

Diputuskan, membenarkan tuntutan plaintif-plaintif terhadap defendan pertama dan kedua dengan kos dan menolak tuntutan plaintif-plaintif terhadap defendan ketiga dengan kos:

(1) Saksi pakar defendan kedua adalah ahli Persatuan Perlindungan Perubatan, sebuah persatuan yang memperuntukkan insurans untuk membela doktor-doktor dalam litigasi, yang mana defendan pertama dan kedua adalah ahlinya. Dalam keadaan tersebut, walaupun saksi pakar ini mungkin tidak berat sebelah dan jujur, pendapatnya walau bagaimanapun besar kemungkinan tidak bebas. Selanjutnya, mahkamah ini terikat dengan keputusan Mahkamah Rayuan di dalam kes *Foo Fio Na v Hospital Assunta & Anor* [1996] 6 MLJ 738 untuk memutuskan bahawa keterangan saksi pakar kedua defendan-defendan berkepentingan sendiri

oleh sebab saksi ini mempunyai kepentingan di dalam keputusan memihak kepada defendan pertama dan kedua. Oleh itu, adalah tidak selamat untuk mahkamah ini bersandar atas keterangan sedemikian untuk memastikan perbicaraan yang adil dan tidak ada pemberatan yang boleh diberikan bagi pendapat pakar ini (lihat perenggan 20).

(2) Saksi pakar plaintif-plaintif adalah pakar onkologi, tetapi mahkamah ini perlu mengambil perhatian bahawa kedua-dua defendan pertama dan kedua bukan pakar onkologi tetapi pakar perubatan dan perlu dibicarakan dalam kedudukan mereka. Standard berjaga-jaga di antara pakar onkologi, yang mengkhusus dalam bidang kanser dan rawatan kanser, dan pakar perubatan, yang khusus dalam perubatan dalaman, adalah jelas berbeza. Oleh demikian mahkamah tidak boleh membuat keputusan mengenai defendan pertama dan kedua melalui standard pakar onkologi, yang mempunyai kemahiran berbeza, tetapi dengan apa yang seorang doktor yang munasabah dalam kemahiran tersebut akan lakukan (lihat perenggan 22).

(3) Saksi pakar defendan-defendan menegaskan bahawa tidak ada kausa untuk mengesyaki penyakit kanser kolon kerana tidak ada perubahan dalam kebiasaan membuang air besar oleh si mati. Walau bagaimanapun, mahkamah ini mendapati bahawa semasa si mati berjumpa dengan defendan pertama pada 15 Disember 2000, tanda-tanda dan simptom-simptom masih tidak melibatkan apa-apa perubahan pada kebiasaan membuang air besar tetapi defendan-defendan telah menjalankan endoskopi dan ujian-ujian lain yang menjurus kepada diagnosis penyakit kanser kolon. Oleh demikian perubahan dalam pembuangan air besar yang saksi pakar defendan-defendan tekankan sebagai tanda jelas atau simptom dalam kes kanser kolon bukan ujian tasit untuk mengenalpasti kemungkinan ada atau tidaknya kanser kolon, khususnya pada si mati. Walau apa pun, tidak ada keterangan bahawa defendan pertama dan kedua telah mempersoalkan atau menyiasat apa-apa perubahan dalam kebiasaan membuang air besar oleh si mati (lihat perenggan 23).

(4) Doktor-doktor tersebut mempunyai kewajipan kepada si mati untuk berusaha, berhati-hati, menggunakan pengetahuan, kemahiran dan berjaga-jaga dalam menjalankan rawatan. Daripada fakta dan keterangan secara keseluruhannya, mahkamah ini mendapati bahawa defendan pertama dan kedua sebagai pakar perubatan yang berpengalaman sepatutnya menyelidik secara lanjut keadaan kesihatan si mati sebelum tahun 2000. Fakta bahawa si mati telah sebanyak empat kali mengadu mengalami simptom yang serupa, apabila dipertimbangkan secara bersama, patut membangkitkan keraguan defendan pertama dan kedua untuk menyelidik secara lanjut. Berdasarkan lima episod aduan kesihatan serupa oleh simati, di antara 15 Disember 1992 sehingga

5 Oktober 2000, mana-mana doktor yang mempunyai kemahiran dan pengalaman seperti defendan pertama dan kedua akan kemungkinan memerintahkan penyiasatan lanjut yang perlu untuk menangkis kemungkinan penyakit lain, termasuk kanser. Dengan itu, kegagalan atau peninggalan defendan pertama dan kedua untuk menyelidik secara lanjut sebelum 15 Disember 2000 membentuk pelanggaran standard berjaga-jaga dan membentuk kecuaian pada pihak mereka (lihat perenggan 26).

(5) Kausa tindakan semasa bermula pada 15 Disember 2000 apabila si mati disahkan mengalami kanser kolon. Mengira enam tahun daripada 15 Disember 2000, had masa bermula pada atau kira-kira 15 Disember 2006. Oleh sebab guaman plaintif-plaintif difailkan pada 12 Januari 2006, ia adalah masih dalam had masa dan s 6(1) Akta, tidak beraplikasi kepada defendan kedua (lihat perenggan 29).

(6) Keterangan defendan pertama dan kedua menunjukkan bahawa mereka adalah kontraktor bebas yang semata-mata mempunyai perjanjian dengan defendan ketiga untuk, antara lain, menggunakan kemudahannya. Plaintif mempunyai beban membuktikan bahawa defendan ketiga adalah bertanggungjawab secara vikarius bagi tindakan dan peninggalan defendan pertama dan kedua tetapi gagal mengemukakan apa-apa keterangan untuk membuktikannya. Oleh demikian, plaintif-plaintif gagal membuktikan kes mereka terhadap defendan ketiga (lihat perenggan 30–32).

(7) Plaintif-plaintif tidak mengemukakan apa-apa keterangan untuk menunjukkan bahawa jika bukan disebabkan oleh kelewatan yang didakwa dalam diagnosis kanser kolon si mati, keadaan kesihatannya, prognosis dan kesudahannya akan berbeza. Walau bagaimanapun, mengambil kira kesakitan dan kesengsaraan yang dialami oleh si mati kerana kelewatan diagnosis, mahkamah ini memutuskan bahawa sejumlah RM100,000 adalah award yang adil bagi kesakitan dan kesengsaraan si mati. Plaintif-plaintif juga diawardkan ganti rugi khas berjumlah RM8,280, sebagai kos penjagaan yang dibelanjakan oleh plaintif-plaintif dalam menjaga si mati (lihat perenggan 40).]

Notes

For cases on conflicting testimony, see 7(1) *Mallal's Digest* (4th Ed, 2011 Reissue) paras 1690–1694.

For cases on professional negligence, see 12 *Mallal's Digest* (4th Ed, 2011 Reissue) paras 1348–1428.

Cases referred to

Aik Ming (M) Sdn Bhd & 8 Ors v Chan Ching Yuen & and another appeal [1995] 2 MLJ 770; [1995] 3 CLJ 639, CA (refd)

Best v Samuel Fox & Co [1952] 2 All ER 394, CA (refd)
Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, QBD (refd)
Bonham-Carter v Hyde Park Hotel Ltd (1984) 64 TLR 177, HL (refd)
Dharam Singh Dhillon v Ibrahim Shaaban & Anor [1995] MLJU 51; [1995] 4 CLJ 207, HC (refd)
Dr Shanmuganathan v Periasamy s/o Sithambaram Pillai [1997] 3 MLJ 61, FC (refd)
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593, FC (refd)
Foo Fio Na v Hospital Assunta & Anor [1999] 6 MLJ 738, HC (refd)
Lai Chi Kay & Ors v Lee Kuo Shin [1981] 2 MLJ 167 (refd)
Lee Sau Kong v Leow Cheng Chiang [1961] MLJ 17, CA (refd)
Ngooi Ku Siong & Anor v Aidi Abdullah [1985] 1 MLJ 30, FC (refd)
Ong Ah Long v Dr S Underwood [1983] 2 MLJ 324, FC (refd)
Paramill Sdn Bhd & Anor v Datuk Joseph Pairin Kitingan [2007] 7 MLJ 289 ; [2007] 6 CLJ 192, CA (refd)
Payremalu a/l Veerappan v Dr Amarjeet Kaur & Ors [2001] 3 MLJ 725, HC (refd)
Rogers v Whitaker (1992) 175 CLR 479, HC (refd)
Sam Wun Hoong v Kader Ibramshah [1981] 1 MLJ 295, HC (refd)
Sim Ah Song & Anor v Rex [1951] MLJ 150 (refd)
Soon Peng Yam & Anor v Bank of Tokyo-Mitsubishi (Malaysia) Bhd [2004] 2 MLJ 31, CA (refd)
Tan Sri Khoo Teck Puat & Anor v Plenitude Holdings Sdn Bhd [1994] 3 MLJ 777; [1995] 1 CLJ 15, FC (refd)
Whitehouse v Jordan & Anor [1981] 1 All ER 267, HL (refd)
Wong Swee Chin v PP [1981] 1 MLJ 212, FC (refd)
Wu Siew Yong v Pulau Pinang Clinic Sdn Bhd & Anor [2011] 3 MLJ 506; [2011] 1 CLJ 255, HC (refd)

Legislation referred to

Limitation Act 1953 s 6, 6(1)

Ganesh Ponniah (M Amiraizat Abdul Rani and Mohd Hussain Ibrahim with him) (Karpal Singh & Co) for the plaintiff.
Darryl SC Goon (Raja, Darryl & Loh) for the first and second defendants.
JJ Chan (Shearn Delamore & Co) for the third defendant.

Chew Soo Ho JC:

THE PARTIES

[1] The first plaintiff is the husband while the second plaintiff is the son of Madam Saradhamani a/p Doraisamy Gopal ('the deceased') who passed away on 8 February 2005 and both the plaintiffs are the administrators of her estate.

[2] Both the first and second defendants are consultant physicians and were practicing at all material times at the Gleneagles Medical Centre ('the hospital') owned by the third defendant.

BRIEF FACTS OF THE CASE

[3] The deceased had been consulting the first defendant and/or the second defendant at the hospital of the third defendant for her medical illness or condition as early as 7 January 1980 before her demise. Since 15 December 1992 until before 15 December 2000, the deceased's medical illness or condition at her various consultations with the first or second defendants was diagnosed by first or second defendants to have suffered from either *gastroenteritis* or food poisoning.

[4] On 15 Deember 2000 when the deceased consulted first defendant with her signs and symptoms at that material time, the first defendant ordered endoscopy, ultrasound of the deceased's abdomen and a *barium enema*; tests on the deceased's stools and blood were also carried out and the results show that the deceased was suffering from cancer of the colon which had spread to her lymph nodes, liver, lungs and bone at the third stage. Hemicolectomy (surgery) was earned out by surgeon Dato' Dr Peter Vanniasingham to remove the malignant tumour on 20 December 2000. Following that, the deceased had undergone chemotherapy and radiation which continued until she passed away on 8 February 2005. On this fact that the deceased was only diagnosed of colon cancer in December 2000 when it could have been diagnosed much earlier by the first and/or the second defendants, the plaintiffs alleged negligence on the part of the first and second defendants basically that they had failed in their duty of care to diagnose the colon cancer of the deceased earlier than 15 December 2000 contending that the deceased had been presenting similar symptoms before 15 December 2000 since her visit in 1992 and/or that the first and second defendants had missed or wrongly diagnosed the deceased resulting in the deceased having to undergo pain and suffering. Hence the plaintiffs claimed various damages on the tort of negligence against the defendants. Defence of the first and second defendants is essentially that there were no signs or symptoms of any colon cancer in the deceased prior to her consultation on 15 December 2000. There was no indication of the colon cancer that would have led a medical doctor practising as a consultant physician treating the patient as the first and second defendants to reasonably embark on an investigation for colon cancer. However, on 15 December 2000, the variance of the signs or symptoms of the deceased had warranted such investigation for which first defendant initiated and it led to the ultimate diagnosis of colon cancer. The first and second defendants denied the allegation of negligence. The second defendant in addition pleaded limitation under s 6 of the Limitation Act 1953.

[5] The third defendant contended that they are not vicariously liable for the acts or omissions of the first and second defendants as the first and second defendants were not the servants or employees or agents of the third defendant's hospital at all material times. Alternatively, they also contended that the first and second defendants had not been negligent in their care and/or management of the deceased.

THE ISSUES

[6] The issues that can be deduced from the facts and evidence in this case are as follows:

(a) whether the failure or omission of the first and second defendants to investigate and diagnose the deceased to have suffered from colon cancer earlier than 15 Deember 2000 constitutes a breach of the duty of care and negligence;

(b) from the conflicting opinions of the experts called by both the plaintiffs and the first and second defendants, which of the opinions would be more probable in the circumstances of this case to assist this court in determining the standard of care expected of the first and second defendants as consultant physicians;

(c) whether limitation applies to bar the suit against the second defendant whom the deceased consulted only on three occasions, the last of which was on 7 May 1997 which was eight years and nine months when the plaintiff filed this suit on 12 January 2006;

(d) whether the plaintiffs have proved that third defendant is vicariously liable for the acts or omission of the first and second defendant; and

(e) if the defendants are found to be negligent, whether the plaintiffs had proved the damages as claimed.

EVALUATION AND FINDINGS

The first and second issues

[7] The first and second issues as stated above are closely related that it is appropriate to consider them together since the evidence and opinions of the experts may assist this court in the determination of the standard of care as expected of the first and second defendants practising as consultant physicians which bears the nexus whether the first and second defendant were negligent in their conduct as such consultant physicians in their diagnosis and/or their failure to diagnose the deceased to have suffered from colon cancer earlier than her consultation on 15 December 2000.

[8] It is well established at common law that there is such a doctor and patient relationship which signifies the duty of care owed by a doctor to his patient to diagnose, advise and treat his patient; no contractual relation is necessary. In *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593 (FC), Siti Norma Yaakob FCJ (as she then was) said of such duty of care at p 601:

> [24] At common law, the duty of care owed by a doctor arises out of his relationship with his patient. Without the doctor and patient relationship, there is no duty on the part of the doctor to diagnose, advise and treat his patient.
>
> [25] That duty of care has been aptly described by Lord Hewatt CJ in *R Bateman* (1925) 94 LBKB 79 to be as follows:
>
> > If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment and the patient submits to his direction and treatment accordingly; he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor it is necessary that the service be rendered for reward.

[9] The undisputed fact in the instant case is that the deceased, before her death, had been consulting the first and/or second defendants as a patient for her illness or medical condition for a considerable period of time since 1980 until she was diagnosed with colon cancer sometime on or around 15 December 2000. The relationship of doctor and patient is clear and undisputed and by this relationship, the first and second defendants as consultant physician would owe a duty of care to the deceased to diagnose, advise and use diligence, care, knowledge, skill and caution in administering treatment on the deceased. The principal allegation of the plaintiffs against the first and second defendants as stated earlier is basically that the first and second defendants had failed to diagnose the deceased with colon cancer earlier than 15 December 2000 or had wrongly diagnosed or missed in their diagnosis of the illness of the deceased when she had presented with the similar signs and symptoms which warranted investigation to detect such possibility of colon cancer earlier. Hence the failure of the first and second defendants to conduct timely and proper investigations on the deceased over a prolong period of time, the failure to record a proper medical history of the deceased and the failure to treat the deceased in a manner consistent with the standard of care expected of the first and second defendants as experienced consultant physicians practising in private hospital in Penang constitute medical negligence on the part of the first and second defendants. The plaintiffs submitted that the diagnosis of the deceased to be suffering from colon cancer on the occasion of 15 December 2000 could and ought to have been done at an earlier stage, given the medical history, complaints that she raised, the symptoms/signs that were presented and all other materials, facilities available to the first and second defendants

coupled with her age and her actual condition. Relevant investigations and tests were never done earlier, it was submitted, purely because the first and second defendants had failed to diagnose the deceased's true and actual condition at an earlier stage and it was a result of negligence and/or missed or wrongful diagnosis. The negligence as submitted are: failure to give sufficient weight to deceased's complaints and symptoms; failure to conduct medical examinations on a regular basis as to monitor and supervise her recovery or condition; failure to attend and examine her adequately at all stages of her treatment; failure to arrange follow up or to pursue results of tests undertaken on her; failure to advise her to contact the first and/or second defendants again if her condition did not improve; failing to spend an adequate amount of time to examine her; failing to verify or reassess the initial diagnosis of her condition; and failing to use available time and resource to perform routine tests, which include thorough investigation of her low hemoglobin count, thorough investigation as to the cause of her anemia; detailed abdominal examination (due to recurrent abdominal pain and altered bowel movements) such as barium meal, stool for occult blood and endoscopy/colonscopy. The plaintiff contended that as a consequence of such negligence that the deceased's cancer spread from her colon to the lymph nodes, liver, lungs and bones and as a consequence, the deceased was subjected to immense and prolonged pain and suffering having to undergo surgeries, chemotherapy, radiation, daily doses of morphine until she was bed-ridden from 5 November 2004 and she succumbed to cancer on 8 February 2005. Since the plaintiffs alleged negligence encompasses a period of almost 20 years from 1980 till before 15 December 2000, the deceased's medical record tendered in court would be of paramount importance to determine whether there is basis for the plaintiffs' allegation of negligence on the first and second defendants and/or whether as alleged by the first and second defendants that there were no signs and symptoms of any cancer in the deceased up to before her consultation on 15 December 2000 to justify further investigation or that the colon cancer if present was silent and did not cause or produce any symptoms or signs to warrant any investigation for such cancer.

[10] The deceased had consulted the first and second defendants on eight occasions in total commencing from 7 January 1980 till her last visit on 15 December 2000. The chronological consultation had been listed out by learned counsel for the first and second defendants in submission which I found to be well founded from the evidence of witnesses and documentary evidence vide bundle B. Thus, I reproduce them with some amendments as follows:

(1) 7.1.1980

Circumstance: The records show that the Deceased was admitted into the 3rd Defendant Hospital at around 3.15 a.m. by Medical Officer by the name of Dr. Khoo Hock Lye. The Deceased was seen by the 1st Defendant later that morning at between 9.00 a.m. to 10.00 a.m.

History, signs & Symptoms:

(i) Generalized abdominal colic (abdominal pain)

(ii) Diarrhoea

(iii) Vomitted once

(iv) Stools yellowish, brownish and watery

(v) Took some stale food earlier in the preceding day

Discharge: It is recorded that the Deceased 'Improved by morning" and 'Requested for early discharge'

Diagnosis & Management: The Deceased was treated for food poisoning.

Had a history of frequent abdominal pain and tenderness following a repair that was carried out on her right fallopian tube at the General Hospital in Penang in 1970.

(2) 30,5.1983

Circumstance: Some 3 years later after her last consultation, the Deceased came to the 3rd Defendant Hospital again on 30.5.1983. She was admitted at about 9.45 a.m. The Deceased was seen by the 1st Defendant. She was referred to the 1st Defendant by a General Practitioner, one Dr. Narmal Singh.

History, signs & Symptoms:

(i) Blurred vision

(ii) Headache

(iii) Giddiness

(iv) Nausea

It was recorded that the Patient was under considerable strain and that she was having heavy periods.

Tests, diagnosis & Management: A urine test and a blood test were ordered. The results were normal except for the act that her haemoglobin level was slightly low at 9.7 g, %. As the Deceased had heavy menses and her haemoglobin level was lower than normal, she was referred to a Consultant Obstetrician & Gynaecologist (one Dr. Tharmaratnam) for further management. In the words of the 1st Defendant 'The Patient's symptoms of concern pointed to a gynaecological cause which required the attention of a specialist in that field, i.e. a Consultant Obstetrician and Gynaecologist'. Blood test disclosed an elevated white cell count in the Patient consistent with the presence of an infection.

Discharge: The Deceased was discharged in the afternoon of the following day. Based on the notes of Dr. Tharmaratnam, he diagnosed uterine fibroids and advised the Deceased to undergo a hysterectomy (surgical removal of the uterus).

(3) 15.12.1992

Circumstance: Some 9 years after the last consultation, the Deceased came to the 3rd Defendant Hospital and was admitted at around 7.50 a.m. The 1st Defendant attended to the Patient.

History, signs & Symptoms:

(i) Loose stools

(ii) Vomiting

(iii) Diarrhoea

(iv) Pain

(v) Slight dehydration

(vi) Slight distension

Tests, diagnosis & Management: The Patient was already being treated and medication was given. The 1st Defendant found the treatment and medication to be appropriate and did not interfere. The Patient was diagnosed with 'Gastroenteritis' and 'Anaemia'. The Patient's haemoglobin level was found to be 9.9. gm %. There was no complaint of any symptoms or adverse medical signs in relation to the Patient's anaemia.

Blood test disclosed an elevated white cell count in the Deceased, consistent with the presence of an infection.

Discharge: The Deceased's presenting symptoms was resolved by the following morning (within 24 hours). The Deceased was well enough to be discharged the following day and she was discharged on 16.12.1992 after having been reviewed by the 1st Defendant. According to the 1st Defendant, he did advise the Deceased to have her anaemia investigated but this was not acceded to.

(4) 13.10.1993

Circumstance: On this occasion the Deceased was attended to by the 2nd Defendant at about 1.45 p.m. in the 3rd Defendant Hospital.

History, signs & Symptoms:

(i) Diarrhoea

(ii) Vomiting

(iii) Left sided abdominal pain

(iv) No fever

Tests, diagnosis & Management: Diagnosed with and treated food poisoning. Blood test disclosed an elevated white cell count in the Patient, consistent with the presence of an infection.

Discharged: Deceased was better with observations normal and she was discharged the following day on 14.10.1993.

(5) 28.8.1994

Circumstance: Almost a year later the Deceased presented with slight abdominal pain. She was attended by the Medical Officer and the 2nd Defendant in the 3rd Defendant Hospital.

History, signs & Symptoms:

(i) General condition fair

(ii) Slight abdominal pain

A (iii) Loose stools

(iv) Abdominal cramps

(v) No pallor

B Tests, diagnosis & Management: Deceased was diagnosed with and treated for food poisoning. Blood test was ordered but was not carried out as the Deceased insisted on discharge.

Discharged: Deceased was well by 8 a.m. and insisted on discharge. The deceased was discharged in the morning of 28.8.1994.

C (6) 7.5.1997

Circumstance: Almost 3 years later the Deceased presented with colicky abdominal pain at around 10 p.m. on 7.5.1997. She was attended to by the Medical Officer and the 2nd Defendant in the 3rd Defendant Hospital.

D Circumstance: Almost 3 years later the Deceased presented with colicky abdominal pain at around 10 p.m. on 7.5.1997. She was attended to by the Medical Officer and the 2nd Defendant in the 3rd Defendant Hospital.

History, signs & Symptoms:

E (i) Colicky abdominal pain

(ii) Nausea

(iii) No vomiting

(iv) Diarrhoea

F (v) No fever

Tests, diagnosis & Management: Deceased was diagnosed with and treated for food poisoning. Blood test disclosed an elevated white cell count in the Deceased, consistent with the presence of an infection.

G Discharged: Deceased was well on the morning of 8.5.1997. The deceased no longer had diarrhoea or pain.

(7) 5.10.2000

Circumstance: Some 3 years 5 months later, the Deceased presented with abdominal pain, diarrhoea and vomiting at around 5.00 p.m. on 5.10.2000. She was attended to by the Medical Officer and the 1st Defendant in the 3rd Defendant Hospital.

H History, signs & Symptoms:

(i) Abdominal pain

I (ii) Diarrhoea

(iii) Vomiting

(iv) Febrlie

(v) Pain

(vi) Mild pallor

(vii) No Jaundice or shortness of breath

(viii) No oedema

Test, diagnosis & Management: Patient was diagnosed with and treated for food poisoning. Blood test disclosed an elevated white cell count in the Deceased consistent with the presence of an infection.

Discharged: Deceased was well on the morning of 6.10.2000 and she was discharged. Diarrhoea and vomiting had ceased.

(8) 15.12.2000

Circumstance: Slightly over 2 months after her last visit, the Deceased called at the 1st Defendant's clinic. This was unlike the previous occasions where she came through the Accident & Emergency upon an acute/urgent event. The Deceased was admitted.

History, signs & Symptoms:

(i) Intermittent abdominal pain

(ii) Pain was on both sides of abdomen

(iii) Pain after every meal

(iv) No vomiting

(v) No constipation

(vi) Stools normal

(vii) No tenderness in abdomen

Tests, diagnosis & Management: 1st Defendant ordered endoscopy, ultrasound of the abdomen and a barium enema. Tests were carried out on the Deceased's stools and blood. The deceased was referred to a surgeon Dato' Dr. Peter Vanniasingham for further treatment and management. The deceased was subsequently diagnosed with an 'apple core' malignant tumour, which was later confirmed to be cancer of the colon. The Deceased then underwent a hemicolectomy (surgery) on 20.12.2000 under Dato' Dr. Peter Vanniasingham.

[11] Since the subject of contention by both parties is centred on the signs or symptoms presented by the deceased to the first and second defendants which plaintiffs contended that such signs or symptoms warrant investigation for colon cancer whereas first and second defendants contended otherwise, I will turn to the evidence of the expert witnesses called by respective parties for assistance and the medical literatures referred to and produced by them particularly in this aspect of the contention by the parties. The three expert witnesses are Dr Muhammad Ali Khalid ('PW1') called by the plaintiffs, Dr Mohamed Akhtar bin Mohamed Ditali Qureshi ('DW3') and Dr Arumugam Nadarajah ('DW4') who were called by the defence. All three expert witnesses had tendered their respective witness statement ('WS') marked as exhs P1, D9

and D16 respectively as well as their written opinion produced and marked as exhs P2 (bundle B pp 384–385), D12 and D17 and D17A respectively.

[12] PW1 said in his WS P1 that he is from Pakistan. He is an oncologist and radiotherapist presently doing field studies in Kuala Lumpur in alternative medicine focused on cancer prevention and cure. He said he had been a doctor practising radiation therapy for more than 14 years initially at General Hospital for oncology in Lahore from 1995–2002 involving preparation of detailed oncology treatment plan, supervision and teaching students on radiation therapy procedures and principles. He had also written and published papers on prevention of radiation effects; he had published a book regarding 'Food and Cancer' and several articles regarding 'Cancer and Environment'. Referring to the signs or symptoms of anemia, diarrhea, abdominal pain and vomitting found in the medical record of the deceased. PW1 is of the opinion that the deceased's case is classical presentation of colon cancer since 1992–2000. His main querry seems to be on the chronic anemia which was not ruled out. Hence, his opinion can be discerned to be that the above signs or symptoms of anemia, diarrhea, abdominal pain and vomitting are the classical presentation of colon cancer. In brief, he opined that colon cancer had existed in the deceased since 1992 until the year 2000.

[13] DW3, a consultant surgeon and Head, Division of Surgery at Sunway Medical Centre, is also a colorectal surgeon. He holds the following academic qualifications: MBB Ch Hons (Dublin), BAO, LRCP & S (Ireland), BSC Hons (Dublin), FAMM FRCS (Ireland), FRCS (England), FICS (UK), FRCS England (Gen), M Ch (Dublin), inter alia. Besides being an invited examiner for medical examinations in five local universities and college. DW3 has also been a Professor in surgery and has been involved in teaching, conferences/workshops etc. He had undergone numerous higher surgical training, has vast clinical experience in various surgery, has made numerous presentations and lectures and has also presented many publications including on the subject of colorectal cancer. He has also written a number of books and booklets. His curriculum vitae is produced as exh D10. According to DW3, 80% of his surgeries involve large bowel ie the colon and rectum and he has been performing such surgeries since 1991. As colorectal surgeon, DW3 said it is within his area of practice and specialty to diagnose among other things, colon cancer and he has diagnosed more than 1,000 colon cancer patients as at the date of the trial. On the deceased's complaints, signs and symptoms prior to 15 December 2000, DW3 holds the opinion that they are not indicative of colon cancer. He gave his reasons: firstly, the deceased had six episodes of nausea and vomiting, colicky abdominal pain and diarrhea which resolved within 24 hours; that is classical of acute *gastroenteritis* whereas in patients with colorectal cancer, the symptoms persists for several weeks and do not improve; secondly, the anaemia in the deceased was chronic and had remained stable for

several years until her visit in December 2000 when there was a significant deterioration of the anaemia for the first time, obviously as a result of the recent occult (unseen) bleeding from the cancer; thirdly, there was no indication that the deceased was in the risk group of patients for developing colorectal cancer; and fourthly, following the removal of the colon cancer on 3 May 2002, the deceased continued to have episodes of acute *gastroenteritis* and her chronic anaemia had returned to its usual levels seen before for several years. DW3 referred to three publications. From the publication on colon cancer and its symptoms by Mayo Clinic, USA ('exh D13A'), the signs and symptoms of colon cancer include:

> A change in your bowel habits, including diarrhea or constipation or a change in the consistency of your stool for more than a couple of weeks. Rectal bleeding or blood in your stool. Persistent abdominal discomfort, such as cramps, gas or pain. A feeling that your bowel doesn't empty completely. Weakness or fatigue. Unexplained weight loss.

[14] The second publication from Cambridge University Hospitals titled *About bowel cancer* ('exh D13B'), the most common symptoms of bowel cancer are stated as:

- a persistent change in bowel habit, especially going to the toilet more often or diarrhoea for several weeks;
- bleeding from back passage without any obvious reason;
- abdominal pain, especially if it is severe; and
- a lump in your abdomen.

> Please remember that these symptoms do not necessarily mean that you have bowel cancer, but if you have one or more of these symptoms for four to six weeks, you should see your GP.

[15] The third publication is the medical text entitled *Surgical Diagnosis and Management — A Guide to General Surgical Care* by David C Dunn MB, MChu FRCS, a consultant surgeon, Adden-brooke's Hospital, Cambridge and Nigel Rowlinson MB, BChu (exh D13C) on the topic of 'Change in bowel habit' where the learned authors said:

> A change in bowel habit is a serious symptom and must always be investigated if it persists for more than three weeks, especially if the patient is over 30. It is most commonly due to colonic disease and possible causes include:
>
> Inflammation: ulcerative colitis, Crohnis disease, diverticular disease. Neoplasia: polyps, carcinoma of the colon.
>
> Other less common causes of a change in bowel habit are pancreatic disease, chronic mesenteric ischaemia and gastric and small bowel obstruction …

[16] From another publication by the Malaysian Oncological Society on *Diagnosing Cancer* ('exh 11'), it states:

> Before diagnosis of cancer is made, a patient typically presents with a medical problem such as any abnormal bleeding, pain, unusual lumps and lumps, cough, or changes in bowel habits to a specialist doctor …

[17] DW3's emphasis of the signs and symptoms of colon cancer seems to be on the change in bowel habits which, however does not seem to exist in the case of the deceased. DW3 holds the view that anaemia in the deceased remained stable for several years and it did not, therefore, warrant basic tests on it to rule out colon cancer but it was particularly investigated prior to 15 December 2000 and the episodes of nausea, diarrhea, vomiting, colicky, abdominal pain do not merit further investigation at the material times of the episodes from December 1992 to October 2000. They resolved within 24 hours. If the symptoms were removed within 24 hours upon consultation, DW3 said it is impossible for the deceased to have had colon cancer. The deceased's presentation prior to 15 December 2000, in DW3's view, is not that of colon cancer but an acute *gastroenteritis*. He asserted that for patients with colorectal cancer, the symptoms persists for several weeks and do not improve. In the case of the deceased, DW3 said that there was no indication of any recognised blood in stool, sustained change in bowel habits which is continuous for one to two weeks and does not improve inter alia, whether singularly or cumulatively prior to December 2000. As to the deceased's tumour which was 3–5 cm, DW3 said it was a small one and could have been there for 9–12 months. He is emphatic that it is impossible for fthe deceased's symptom of abdominal pain in 1992 to 1997 to have disappeared and only reappeared again in the year 2000; the pain ought to be there if the cancer was not removed. He further disagrees with PW1's opinion saying that if the deceased had cancer since 1992, she would not have survived till 2000.

[18] The next expert is DW4 called by the defence. DW4 is a consultant physician and endocrinologist practising in Pantai Hospital, Kuala Lumpur and a registered specialist in internal medicine and endocrinology with the Malaysian National Specialist Register. From his curriculum vitae produced as D16A, he holds MBBS from University of Singapore (1962), MRCP Edinburgh (1967), MRCP London (1967), MD University of Singapore (1974), FRCP London (1985) and FRCP Edinburgh (1985). He has 47 years experience in the practice of general medicine and 41 years of experience as specialist in the same field. Over the years, he has seen and diagnosed many patients with colon cancer. Learned counsel for the plaintiffs had objected to this witness to be called on the ground basically that his expert report was not enclosed in the bundles of documents and that his expertise as endocrinologist is not relevant. I overruled the objection because DW4's expert report had been supplied to learned counsel for the plaintiff more than a month before this

witness testified. On his expertise, he is also a consultant physician, same as both the first and second defendants and the field of internal medicine is indeed relevant as to the subject matter of colon cancer in this case. This court will ultimately determine after having heard the whole of DW4's evidence whether he is an expert in this field. DW4 said in his witness statement ('exh D16') that he is a witness of opinion as an expert and owe an overriding duty to the court. He has no personal relationship with the defendants or the plaintiff. However, in cross-examination, DW4 said that he is a member of the Medical Protection Society of which DW1/the first defendant and DW2/the second defendant are also members. In his report exh D17, it states that it was prepared at the request of the Medical Protection Society initiated by solicitors for the defendants. This society provides insurance to defend doctors in litigation. On this point, learned counsel for the plaintiffs submitted the case of *Foo Fio Na v Hospital Assunta & Anor* [1999] 6 MLJ 738 where the Court of Appeal has held, inter alia, that:

> Held,
>
> (5) … Dr Gibson was also a council member of the Medical Protection Society, a society established to protect any undoing or negligence of a member to which the second defendant belonged as a member. Dr Gibson's evidence was therefore self-serving as he had an interest in the decision to favour the second defendant and his evidence could not therefore be relied upon …

[19] His Lordship Mokhtar Sidin JCA in so holding cited what had been stated by Lord Wilberforce in *Whitehouse v Jordan & Anor* [1981] 1 All ER 267 at p 276 as follows:

> While some degree of consultation between experts and legal advisers is entirely proper, it is necessary that expert evidence presented to the court should be, and should be seen to be the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect but self defeating.

[20] Learned counsel for the plaintiffs submitted that the evidence of DW4 is self serving on the society which has interest in the decision to favour the first and second defendants and hence could not be relied upon. It is a fact that DW4 had not seen or treated the deceased before she was diagnosed with colon cancer. His report is based on his opinion from medical records and pleadings submitted to him. As a member of the Medical Protection Society and being so requested by the society's solicitors acting for the sefendants to prepare the report, one cannot erase the element of doubt in the report so prepared and the independence of DW4's opinion. DW4 could probably be unbiased and honest in his opinion. Howsoever it may be, as long as his opinion and product are tainted with the probability of non-independence, it would be unsafe for the court to rely on such evidence to ensure a fair trial. DW4's position is

somewhat similar to Dr Gibson in *Foo Fio Na v Hospital Assunta & Anor* and thus, although this court may have some reservation, this court is bound by the decision held by the Court of Appeal as cited above to hold that the evidence of DW4 being a member of the Medical Protection Society in which first and second defendants are also members, as Dr Gibson, is therefore self-serving as probably, he has an interest in the decision to favour the defendants and his evidence could not therefore be relied upon. In the circumstances, no weight can be accorded to DW4's expert opinion.

[21] Learned counsel for the plaintiffs also submitted that DW3 is probably a member of the Medical Protection Society as well. However, no such evidence was led in DW3's evidence nor was he cross-examined by learned counsel for the plaintiffs. In the absence of any such evidence, there is no basis for this court to accede to the assumption that DW3 is a member of the same society. The court must decide on facts and evidence and not on conjectures, surmises or suspicion.

[22] With the rejection of DW4's evidence, what is left of the expert evidence is the evidence of PW1, the plaintiffs' expert and DW3, the defence's expert. PW1 is an oncologist and radiotherapist. DW3 is a consultant surgeon and also a colorectal surgeon directly involved in surgery work of colon and rectum. According to DW3 the Malaysian position of oncologist is to treat cancer patient after he or she has been confirmed the diagnosis of cancer. Diagnosis is generally done by the specialist in the respective field of specialised medicine. DW3's view is supported by exh D11, the publication by Malaysia Oncological Society which states that 'before a diagnosis of cancer is made, a patient typically presents with a medical problem … to a specialist doctor. This doctor would undertake some investigations to confirm the diagnosis of the problem … If cancer is confirmed, the patient needs to discuss the most appropriate treatment with the oncologist'. I have no doubt of this position. PW1 who is from Pakistan said that oncologist also diagnosed patient for cancer which could probably be the case in his home land but not in Malaysia. This court must bear in mind that both the first and second defendant are not oncologists but consultant physicians and must be judged in their profession as such as distinct from an oncologist. Accepting the position of PW1 as oncologist specialised in cancer and cancer treatment, who had been involved not just in the treatment but diagnosis of cancer, I would venture to say that since his scope is only centred on cancer, any patient who is seen by him or referred to him would be examined in the perspective of whether he or she has suffered from cancer or whether radiotherapy or other treatment should be applied if the patient referred is a cancer patient. In that sense, any patient with symptoms such as anaemia, diarrhea, abdominal pain and vomiting or any other symptoms who consulted PW1 would naturally be investigated in the light of detecting cancer in line with his scope of call. However, in the

perspective of the first and second defendants who specialised in internal medicine which is different from the restrictive specialised scope of oncologist, they have to diagnose and treat the patient in the perspective of internal medicine. To the oncologist, symptoms such as anaemia, diarrhea, abdominal pain and vomiting viewed in his perspective are classical presentation of colon cancer whereas to the consultant physician specialised in internal medicine, the same symptoms are classical presentations of acute *gastroenteritis* or food poisoning. The standard of care between these two specialised fields is thus glaringly different. Therefore, the court cannot judge the standard of care in negligence of the first and second defendant according to the standard of an oncologist and radiotherapist as PW1 or even by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. In *Rogers v Whitaker* (1992) 175 CLR 479, the High Court of Australia has expressed that:

> In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill. But that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam principle has not always been applied …

[23] See *Foo Fio Na v Dr Soo Fook Mun & Anor* where our Federal Court held that the *Rogers v Whitaker* test would be a more appropriate and a viable test of this millennium than the *Bolam* test. The court should determine what the reasonable doctor in that skill would have done and not the profession or an oncologist who is differently skilled although what the profession does in a given situation will be an important indicator of what ought to have been done, but it should not necessarily be determinative. In the final analysis, the court should set the standard of care in negligence, drawing upon the evidence presented; see medical negligence by Michael Jones 1996 pp 610–611 as referred to in *Foo Fio Na v Dr Soo Fook Mun & Anor*. Since the plaintiffs' complaint is confined to the period of consultations from 15 December 1992 to 5 October 2000, I shall consider the deceased's signs and symptoms during this period of her consultations with the first and/or second defendants and the care and/or management undertaken by the first and/or second defendants in addressing her problems to determine whether the failure of the first and second defendants to investigate the deceased's signs and symptoms for colon cancer constitutes a breach of the standard of care in negligence. According to DW3, the deceased's signs and symptoms as recapitulated above on 15 December 1992, 13 October 1993 and 28 August 1994 were all acute food poisoning as the sudden onset of vomitting and diarrhea was completely recovered within 24 hours. However, DW3 had omitted the signs and symptoms of loose stool, the abdominal pain and/or cramp that had also

existed. Accumulatively, would the signs and symptoms be indicative of the necessity to investigate the deceased's colon of any probable illness? Although the interval of these three consultations is about ten months from one to the other and for each occasion, the pain, vomiting, diarrhea etc could probably have been resolved, these signs and symptoms are nevertheless almost similar on each consultation which to this court appear to be signs of recurrence of same or similar problem of the deceased. Did it not ring a bell in the first and second defendants as experienced consultant physicians to probe further to ascertain whether there was something other than mere food poisoning or *gastroenteritis*? On 7 May 1997 which was about 2¾ years from the deceased's consultation on 28 August 1994, the deceased presented herself with colicky abdominal pain, nausea and diarrhea, the signs and symptoms which are quite akin to the previous occasions. Again, the deceased was diagnosed and treated for food poisoning which was receptive and she was discharged the following day. On 5 October 2000 which is about three years five months later, the deceased again presented with almost identical problem of abdominal pain, diarrhea vomitting, febrile, pain and mild pallor and on this occasion, she was similarly diagnosed and treated for food poisoning, which again was receptive; with the symptoms resolved, she was discharged the following morning. Up to this date, looking through all her long medical records, one fact which cannot be denied is that she had been consistently presenting herself with the same or similar problems with symptoms of nausea, diarrhea, vomiting, abdominal pain etc. Nevertheless, DW3 is of the opinion that having seven episodes of food poisoning over a period of 20 years is completely unremarkable. DW3's emphasis is that since there was no bowel change in the deceased, there was no cause to suspect colon cancer and hence no necessity for such investigation. However, on 15 December 2000 which was the occasion when the deceased was finally diagnosed to have suffered from colon cancer, the signs and symptoms presented on this consultation with the first defendant were 'intermittent abdominal pain, pain on both sides of abdomen, pain after every meal, no vomiting, no constipation, stools normal, no tenderness in abdomen'. These signs and symptoms did not involve any change of her bowel habit. Thus, the change in bowel habits which DW3 has emphasised to be the conspicuous signs or symptom in the case of colon cancer is not the tacit test to identify the probability or improbability of having colon cancer particularly in the deceased. Her stools were normal and yet she was confirmed to suffer from colon cancer on this occasion. Perhaps, with the existence of the change in bowel habits, the detection and diagnosis of colon cancer might to be too late to save a patient. As both experts have endorsed, early stage of cancer can be curable but at stage three or stage four, the prospect is slim. Hence, early detection or diagnosis is vital to a patient's survival. In any event, there is no evidence that the first and second defendants had querried and/or investigated on any bowel habit change of the deceased or on her stools. The deceased was born on 21 March 1939. In 1992, she would be 53 years of age and by 5 October 2000, she would be about 61 years six months old. For a woman in the

50–60 years age group who had been consistently suffering from the same or similar symptoms of complaint of nausea, diarrhea, vomiting, abdominal pain, over such a long period of time, would it not be probable that the first and second defendants being experienced consultant physicians having had full knowledge of her medical record of such conditions and taking into account her age of having passed 50 years, should have put the deceased on further investigation such as endoscopy, colonoscopy or other tests to confirm that she could not be suffering from other medical complications than the mere food poisoning or gastroenteritis? Would it not be too late to wait for the acute or glaring signs and symptoms of cancer to surface before embarking to conduct the basic and/or necessary investigations and tests? It is perhaps understandable that when the deceased consulted first defendant or second defendant on the first occasion on 7 January 1980 with the signs and symptoms of abdominal pain, diarrhoea, vomiting and the history of having taken some stale food, she was diagnosed and treated for food poisoning which was receptive by her that no further probe would seem necessary. Her second visit was insignificant as her complaint was on different signs, symptoms and history. On her third consultation on 15 November 1992 with related similar signs and symptoms, it would perhaps still be acceptable that it was some nine years after the deceased's last consultation that perhaps no further investigations and/or tests might be necessary since the deceased was receptive to the treatment prescribed. However, on 13 October 1993 and 28 August 1994 when she presented with similar or same signs and symptoms, I would think that a reasonable, vigilant and cautious experienced consultant physician as the first and second defendants would certainly have alerted themselves of at least some suspicions of any underlying illness and would embark on the basic and/or necessary tests to rule out whatever suspicion that might arise from such recurring similar signs and symptoms judging the age of the deceased. The physicians owed a duty to the patient to use diligence, care, knowledge, skill and caution in administering treatment on the patient which must necessarily include conducting investigation and the necessary tests towards achieving that duty of care. When the patient had subjected herself to the treatment of the consultant physician, I would not think that it would be alarming to her if the basic and/or necessary tests were ordered by the physicians which would generally be upon the patient's consent on the ground that her medical records showed that she had been consistently suffering from the same or similar complaints and that necessitated further investigations or tests. According to medical publication ('exh D18'), screening for colon cancer or colonscopy or barium enema is encouraged for high-risk asymptomatic individual at the age group of 40 years and above and should be repeated every three to five years. Given the signs and symptoms of the deceased who had probably not been screened for the duration of 20 years and the fact that she was in the higher age group with high risk, I cannot perceive why she was not placed on further investigations. If only a little time could be spent to explain the need to do so, I do not think any patient would object for the further basic and/or necessary

tests. Even if this court were to accept that the first and second defendant had deemed it unnecessary to investigate further on the deceased's anaemia, her low hemoglobin count and her white blood count, I cannot be convinced to agree with the first and second defendants that the deceased's signs and symptoms and conditions were asymptomatic of colon cancer when no proper tests such as endoscopy or colonoscopy or stool for occult blood etc were ever carried out. Had the first and second defendants be vigilant, diligent and cautious in the skill as they profess, I would have no doubt that they must suggest to the deceased to undergo at least an endoscopy or colonoscopy when the deceased had consulted them with almost similar complaint times and again. Both first and second defendants are not general practioner but experienced medical specialists. I do not think it is right for them to diagnose and treat the deceased as if it was an isolated case for each consultation ignoring her long history of same or similar signs and symptoms of recurring nature. For that matter, I am more inclined to hold the view that any reasonable doctor in that skill as the first and second defendants having had knowledge of the deceased's medical record, would have embarked on further investigations in the circumstances of this case even in the absence of the medical history that the deceased's close relative had had suffered from cancer for which the court does not attach any blame on first and second defendants for not having so taken from the deceased. The first defendant testified that he had advised the deceased for further tests or investigations but there is no record to substantiate this assertion. Indeed there is no evidence nor any record to show that he had ever asked the deceased to return to the hospital for review after the alleged receptive treatments. Thus, I find it unconvincing to accept his evidence in this respect which is a bare assertion.

[24] DW3 gave his opinion that from the size of the deceased's tumour of 3.5 cm, it could have existed between 9–12 months. On the duration that cancer can take to develop, *Blaylock Wellness Report — Living a Long, Healthy Life* edited by Russell L Blaylock, MD, June 2011 vol 8 No 6 at p 3, has this to say:

> … The reason cancer takes so long to develop is that, in most cases, it results from chronic inflammation. Over many years, released free radicals damage the DNA, which results in activating cancer genes and cancer-promoting cell signaling processes.
>
> Studies have shown that in the vast majority of cancers, a smoldering chronic inflammation existed for as long as 17 years before the cancer developed …

[25] In the light of what Dr Russell Blaylock had said above, DW3's opinion of the deceased's colon cancer having been develop only between nine to 12 months prior to its detection on 15 December 2000 may be subjective and over speculative. I say so for simple reason that no investigation or test for colon cancer had ever been carried out from 1992 to before 15 December 2000. If, for example, colonoscopy was done on the occasion of 7 May 1997 and ruled

out cancer, perhaps, there might be some basis in DW3's opinion as until 15 December 2000 of over three years, cancer which might take time to develop from the smoldering chronic inflammation that had existed, could have developed between 9–12 months from 15 December 2000. That was not the case here. Similarly, the evidence of PW1 that the deceased could have the cancer since 1992, suffered the same defect as DW3's opinion when there is no evidence in support. Unless investigation or test such as colonscopy etc was conducted to rule out any suspicion of tumour, no one can be certain as to when the cancer could have developed in the deceased. It will therefore be improper for the court to rely on uncertainty to arrive at any finding of fact.

[26] From the facts and evidence as a whole, I am of the view that the first and second defendants who are experienced consultant physicians ought to have investigated the deceased's medical condition further by, for example, conducting the basic and/or necessary endoscopy or colonoscopy or other necessary tests prior to 2000 when the deceased had at least on four episodes complained of similar signs and symptoms which cumulatively ought to have raised their suspicions to probe further. Again, on the occasion on 5 October 2000, the deceased presented with similar signs and symptoms as the four previous occasions; yet her medical record was not carefully scrutinised cumulatively to order further investigation or test but the deceased was merely treated as if her similar signs and symptoms appeared for the first time. I do agree that merely because there is a lapse of a year to more than three years between the deceased's consultation that it merits no further investigation. If the first and second defendants were cautious enough to look at the available medical record of the deceased before them and taking into account of her age, I am of the view that further test would not be omitted. I cannot agree with the view that a patient must only be examined and treated on the very occasion of her consultation shutting the eyes on her previous episodes especially when she presented with recurrence of similar signs and symptoms. I also disagree that only where there are indicative signs and symptoms of cancer that the consultant physician will begin to investigate. If that is the case, as in this case, it may be too late because the cancer has attained the third stage which renders prospect of recovery or cure minimum. I would venture to say that given the five episodes of the deceased's similar recurring medical complaint between 15 December 1992 to 5 October 2000, any medical doctor who possesses the skill and experience as the first and second defendants would most probably have ordered a colonoscopy or any other further or necessary investigation or test to determine any complication or rule out any other probable illness including cancer. If the first and second defendants had carried out or ordered the basic and/or necessary investigation on the deceased's condition, it would most probably be that colon cancer could have been detected earlier and the deceased would have the better prospect of recovery. Consequently, I hold on a balance of probabilities that the failure of or the omission by the first and second defendants to investigate further on the deceased's signs and symptoms which

were of similar nature prior to 15 December 2000 and which can be construed as recurring and to diagnose her colon cancer earlier constitutes a breach of the standard of care and negligence on their part.

[27] As to the expert opinions of PW1 and DW3, I make no finding as to which of their opinions that I would prefer save for some of the evidence that has been deliberated herein above. I find that the opinions of the experts would be more reasonable and responsible if the episodes of the deceased's recurring complaints were viewed cumulatively and not distinctively and that the opinion should be that of a specialist doctor in the skill and experience as the two defendants herein. In any event, the responsibility for the determination of every question upon which expert evidence is called rested upon the court and not upon the expert: per Brown Ag CJ in *Sim Ah Song & Anor v Rex* [1951] MLJ 150. The court is the final arbiter, not the experts or witnesses; see *Dr Shanmuganathan v Periasamy s/o Sithambaram Pillai* [1997] 3 MLJ 61 (FC).

The third issue

[28] From the medical record of this case, it is an undenied fact that the second defendant had seen the deceased for three occasions, the last of which was on 7 May 1997. The plaintiffs' suit was filed on 12 January 2006. Section 6 of the Limitation Act 1953 (Act 254) provides:

> 6
>
> (1) Save as hereinafter provided the following actions shall not be brought after the expiration of six years from the date on which the cause of action accrued, that is to say —
>
> (a) actions funded on a contract or on tort;
>
> …

[29] The cause of action accrued on the fact and evidence of this case is on or about 15 December 2000 when the deceased was confirmed to have suffered from colon cancer. Calculating six years from 15 December 2000, the limitation would be on or about 15 December 2006. Since the plaintiffs' suit was filed on 12 January 2006, it is well within time. Therefore s 6(1) of the Limitation Act 1953 does not apply to the second defendant.

The fourth issue

[30] It is the plaintiffs' contention that the first and second defendants were at the material time agents, employees and/or servants of the hospital and the

hospital is thus vicariously liable for the acts and/or omissions of the second defendants. However, no evidence had been produced by the plaintiffs to prove so.

[31] The evidence of the first and second defendants conversely showed that they were independent contractors and self-employed. They merely had an agreement with the third defendant which gave them, among other things, the right to use the hospital's facilities; they received no salary and did not take any instructions or directions from the third defendant. Learned counsel for the third defendant submitted that this aspect of the first and second defendants' evidence was not challenged by the plaintiffs in cross-examination which the plaintiffs ought to have done so in order not to take the defendants' evidence and pass them by as a matter altogether unchallenged citing the passage of Lord Herschell LC as quoted by our Court of Appeal in *Aik Ming (M) Sdn Bhd & 8 Ors v Chan Ching Yuen & and another appeal* [1995] 2 MLJ 710; [1995] 3 CLJ 639. In addition, there is no allegation of any negligence on the third defendant as pleaded by the plaintiffs.

[32] It is trite that the plaintiffs bear the burden of proof as to what they had pleaded against the third defendant. It is a fact that the plaintiffs had led no evidence to prove against the third defendant as pleaded. Further, the plaintiffs seem to accept that first and second defendants were not the employees, servants and/or agents of the third defendant when they failed totally to cross-examine the first and second defendants on the material evidence that they were independent contractors and self-employed but merely had an agreement with the third defendant, inter alia, for the use of the Hospital facilities. In *Soon Peng Yam & Anor v Bank of Tokyo-Mitsubishi (Malaysia) Bhd* [2004] 2 MLJ 31 (CA), His Lordship Alauddin JCA (as he then was) said at p 36:

> … Thus it must be accepted that the failure to cross-examine the defendants on important aspects of their evidence must be treated as acceptance of those parts of their evidence.

[33] See also *Wong Swee Chin v Public Prosecutor* [1981] 1 MLJ 212 (FC); *Paramill Sdn Bhd & Anor v Datuk Joseph Pairin Kitingan* [2007] 7 MLJ 289 ; [2007] 6 CLJ 192, p 215 (CA). Therefore, the plaintiffs are deemed to have accepted the important aspects of the first and second defendants' evidence which exonerate the vicarious liability of the third defendant. It is also settled law that it is not for the defendants to disprove the allegations of negligence of the plaintiffs as the legal burden of proof always rests on the plaintiffs; see *Payremalu a/l Veerappan v Dr Amarjeet Kaur* [2001] 3 MLJ 725, *Wu Siew Yong v Pulau Pinang Clinic Sdn Bhd & Anor* [2011] 3 MLJ 506; [2011] MLJU 1317; [2011] 1 CLJ 255, inter alia. In the circumstances, I hold that the plaintiffs

have failed to prove their case against the third defendant.

The fifth issue

[34] In submission the plaintiffs claimed a revised sum of special damages in the total of RM701,825.78 making up from the costs for the treatment at Glenneagles from 1992 to 2000, treatment and liver surgery at Singapore General Hospital, travel and accommodation for family to Singapore during liver surgery, chemotherapy, nursing care from 5 November 2004 to 7 February 2005 and loss of the first plaintiffs income from February 2001 to 8 February 2005. In addition, the plaintiffs also claimed for aggravated damages in the sum deemed proper by the court and general damages in the sum of RM1m together with interest and costs. The defendants submit that the plaintiffs have failed to prove all those damages as claimed.

[35] In *Ngooi Ku Siong & Anor v Aidi Abdullah* [1985] 1 MLJ 30 (FC) and *Ong Ah Long v Dr S Underwood* [1983] 2 MLJ 324 (FC), the Federal Court had held, inter alia, that special damages in contrast to general damages have to be specifically pleaded and strictly proved. The often quoted dictum of Lord Goddard in *Bonham-Carter v Hyde Park Hotel Ltd* (1984) 64 TLR 177, at p 178 is:

> … the plaintiffs must understand that if they bring actions for damages it is for them to prove their damage; it is not enough to write down the particulars, so to speak, throw them at the head of the court, saying: 'This is what I have lost, I ask you to give me these damages.' They have to prove it.

[36] See *Tan Sri Khoo Teck Puat & Anor v Plenitude Holdings Sdn Bhd* [1994] 3 MLJ 777 ; [1995] 1 CLJ 15 (FC), *Lee Sau Kong v Leow Cheng Chiang* [1961] MLJ 17, inter alia. It is also trite that the burden of proof for damages rests on the plaintiffs; see *Sam Wun Hoong v Kader Ibramshah* [1981] 1 MLJ 295, at p 297 (FC).

[37] On the treatment of the deceased from 1992 to 2000, the plaintiffs claimed for the sum as amended to be RM106,357.78 which revised the pleaded claim for RM257,990.53 from 1992 to 2004 and the plaintiffs have also dropped the claim for 'elbow surgery' as it has aborted in submission. Although the plaintiffs in actual fact, are claiming for the sum of RM106,356.78 as appeared in their submission, yet in evidence vide PW2's (the first plaintiffs) witness statement (P3), he still claimed for RM257,990.53 and elbow surgery of RM12,000. The plaintiffs quite vividly are uncertain of their claim for this item. As special damages must be strictly proved, it is incumbent upon the plaintiffs to prove with the relevant documents, vouchers or receipts as to the charges and the payments made. Unfortunately, no proper

documents had been produced to prove which is the correct sum that the plaintiffs are claiming and that they had expended such sum claimed. I therefore hold that the plaintiffs have failed to prove this item. On the second item of treatment and liver surgery in Singapore General Hospital or RM35,547, the plaintiffs produced the tax invoice marked P23 from the Singapore General Hospital in the sum RM14,450. However, there is nothing stated in this P23 that this cost was for 'treat and liver surgery' of the deceased. There is also no evidence that the liver surgery was as a consequence or effect of the colon cancer. It might probably be so but the burden is on the plaintiffs to prove. I would reckon a medical report to that effect will suffice but no such evidence was led by the plaintiffs in spite of the requirement of strict proof. Since the amount in P23 does not tally with the plaintiffs' claim of RM35,547 for this item and in the absence of any evidence to relate the treatment and liver surgery with the deceased's colon cancer coupled with the fact that the plaintiffs had failed to show that the treatment which the deceased had allegedly undergone in Singapore was not available in Malaysia (see *Dharam Singh Dhillon v Ibrahim Shaaban & Anor* [1995] 4 CLJ 207, at p 212), I must therefore hold that the plaintiffs have failed to prove this item of their claim. Flowing from this, the next item of claim for the cost of accommodation for members of family in Singapore during the treatment in Singapore will not be construed as proved. In any event, no documentary proof was adduced in evidence to substantiate this claim.

[38] For the cost of chemotherapy and medication for lung and bone treatment, the plaintiffs produced certified true copy of official receipts from Klinik Bala marked P25 where the total sum of the six receipts showed RM20,060 while the plaintiffs' claim as submitted was RM22,068 which does not tally with the receipts. There is also no evidence or explanation on the term stated on the receipts as 'lmy …' whether it refers or is related to the chemotherapy. The plaintiffs had not called any witness from Klinik Bala to confirm the said payments were for chemotherapy. Consequently, I cannot come to any finding of fact that these receipts are for chemotherapy. Similarly for the three Diethelm Malaysia Sdn Bhd official receipts, the certified true copy is marked P26 and the two invoices marked P27 and P28, no evidence was led from Diethelm Malaysia Sdn Bhd that these charges and payments related to the deceased's chemotherapy. From P26–28, they do not show that the payments were for chemotherapy. I find that this has failed to satisfy the requirement of 'strictly proved'. The claim for the sum of RM38,688 vide a copy letter allegedly from Penang General Hospital which was not properly proved and which had been rejected by the Court would have no basis. This is a clear example of what Lord Goddard said above that the plaintiffs just wrote down the particulars and 'throw them at the head of the court, saying: This is what I have lost, I ask you to give me these damages' without proving them. On the cost for treatment at Adventist Hospital, P29 (the bills), this was placed under the item of cost of chemotherapy but looking at the description in P29,

I find that nothing is mentioned of chemotherapy treatment. This is again not proved in the absence of any other evidence. On the next item of radiation and treatment at Pantai Mutiara Hospital Penang in the sum of RM30,000 as pleaded, it is clearly abandoned in the plaintiffs' submission. The plaintiffs claimed next the sum of RM11,280 as nursing care for the deceased from November 2004 to 7 February 2005 at RM120 per day. It was admitted by the plaintiffs in evidence and in submission that there was no receipt. One cannot deny the fact that cancer patient especially when bed ridden do need nursing care. It is conceivable that no receipts were obtained from these nurses especially if they were not so employed on a full time basis and payments were made in cash as and when they worked for the day. In the circumstances, I am prepared to allow this claim but since what is pleaded is from November 2004 without the actual date being known and though in submission, it was stated as 5 November 2004 but without any amendment and without evidence how this date came into being, in all fairness, I will calculate this nursing care commencing from 1 December 2004 to 7 February 2005 at RM120 per day which works out to be RM8,280.

[39] For the item of loss of earnings by the first plaintiff from January 2002 to 8 February 2005 at RM20,000 per month, I am inclined to agree with the defendants' submission that this is a claim on behalf of the estate of the deceased and the first and second defendants owe no duty of care vis-a-vis the first plaintiff and the first plaintiff has no cause of action against the first and second defendants for losses allegedly suffered by him as a result of the negligence of the first and second defendants. A third party, in the normal run of cases, will have no direct remedy against the wrong-doer: per Chua J in *Lai Chi Kay & Ors v Lee Kuo Shin* [1981] 2 MLJ 167, at p 171. His Lordship also cited the English case of *Best v Samuel Fox & Co* [1952] 2 All ER 394 which is directly in line with the instant case where Lord Morton considered the situation of a daughter of the injured man having to give up work, which she enjoyed, and stayed at home to nurse a father, who had been transformed into an irritable invalid, as a result of the defendant's negligence, and concluded that she had no right of action against the defendant, since he had not committed a breach of duty towards her. This was because it was a case of the daughter herself suffering a loss and not one of her incurring expense on her father's behalf at all. The first plaintiff position is exactly the same even taking into account the purpose of giving up work was to nurse the injured. Evidence through cross-examination of the first plaintiff and PW4, the partner of the first plaintiff in their legal firm, also shows that there is no justification for the first plaintiff to give up his job or retire since there was no necessity for the first plaintiff to be with the deceased everyday and that there was no medical basis for him to retire to provide care for his wife, the deceased. Moreover, the plaintiffs had employed a nurse to care for the deceased at the material time. Consequently, I hold that the plaintiffs are not entitled to this item claimed.

[40] On general damages, evidence of PW1 indicated that the deceased's cancer could have been there as early as 1992 while DW3 said that in retrospect, he was certain that the cancer was already there in the deceased on her consultation on 5 October 2000 but that the cancer was silent. DW3 opined that the cancer could have developed 9 to 12 months prior to its diagnosis. As this court has stated earlier, without any test or investigation such as colonoscopy earlier than 15 December 2000 to confirm or rule out any cancer tumour, one can never be certain as to when the deceased's colon cancer had been developed. However, if investigation and tests were carried out earlier, cancer could have probably been detected earlier when it was still in its initial stage; the deceased's life would probably be saved and her pain and suffering would probably have been vastly reduced. Be that as it may, I agree with the learned counsel for the first and second defendants that the plaintiffs had led no evidence to show that but for the alleged delay in diagnosis of the colon cancer in the deceased, her medical condition, prognosis and outcome would have been different. Nevertheless, the fact that the deceased was diagnosed only at the third stage of the cancer which had spread to other parts of her organs, and which necessitated treatments and care before she succumbed to the disease, her pain and suffering for this period could not be denied. Balancing the two, I would think that a sum of RM100,000 would be a fair award for the pain and suffering of the deceased.

[41] Aggravated damages was not pleaded specifically in the body of the claim by the plaintiffs but was included as part and parcel of general damages in the final prayer in the statement of claim. In *Halsbury's Laws of England* (4th Ed), Reissue para 1148, it states that:

> 1148. Aggravated damages. Where the plaintiff's claim is for aggravated damages, the pleading should contain a statement to that effect and should set out the facts on which he relies in support of his claim for such damages … The Rules of the Supreme Court do not expressly require that aggravated damages be pleaded, but by application of general principles the plaintiff is required to plead those special facts relied upon in support of the claim.'

[42] Aggravated damage as expressed in *Mc Gregor* on *Damages* (15th Ed), at pp 409–410 means:

> … aggravated damage — that is, as cases of extra compensation to the plaintiff for the injury to his feelings and dignity.

[43] Such damage is considered where there is outrage to person or property and it is to compensate for the injury to the feelings and dignity or pride. There is in the instant case, no such pleading nor evidence as to any outrageous act to the deceased nor any injury to the feelings and dignity of the deceased. The

plaintiffs therefore are not entitled to this claim.

CONCLUSION

[44] For the foregoing reasons, I hold that the plaintiffs have proved the negligence of the first and second defendants on a balance of probabilities but have failed to prove that the third defendant is vicariously liable for the acts or omissions of the first and second defendants. Judgment is therefore entered against the first and second defendants with special damages in nursing care in the sum of RM8,280 and general damages for the pain and suffering of the deceased in the sum of RM100,000 with interest at the rate of 8% from the date of judgment to the date of realisation. Costs of RM10,000 is awarded for the plaintiffs.

[45] The plaintiffs' claim against the third defendant is dismissed with costs of RM8,000.

Plaintiffs' claim against first and second defendants allowed with costs and plaintiffs' claim against third defendant dismissed with costs.

Reported by Kohila Nesan